

# Atlanta West Dermatology, P.C. - Patient Profile

Please Fill Out Completely:

**Patient** Patient ID: \_\_\_\_\_

Patient's Last Name			First Name			MI	
Social Security Number	Date of Birth	Age	Cell Phone		Home Phone		
Address (Street, Route, Apt. No., etc.)				City		State	Zip Code
Marital Status	Sex	Business Phone	Employed By				
Referring Physician	Primary Care Physician	Employer's Address		City	State	Zip Code	

**Guarantor (If patient is a minor, this must be the accompanying parent.)**

Name		Address		City		State	Zip Code
Home Phone	Social Security Number		Sex	Date of Birth	Relationship to Patient		
Employed by				Business Phone			
Employer's Address			City		State	Zip Code	

**Emergency Contact** (Friend or relative not at Patient's address who can get a message to you.) \_\_\_\_\_ Daytime Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_  
 Patient    Top Doc magazine    Yellow pages    Wellstar

**Insurance Information**

Email address: \_\_\_\_\_

**Primary Insurance**

Primary Ins Co: \_\_\_\_\_  
 Policy Holder Name: \_\_\_\_\_  
 Relation to Patient: \_\_\_\_\_  
 Policyholder DOB: \_\_\_\_\_  
 Policyholder SS#: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_

**Secondary Insurance**

Secondary Ins Co: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_  
 Relation to Patient \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_

**DO WE HAVE PERMISSION TO:**

- Leave a message on your home answering machine?     Yes     No  
 Leave a message on your voice mail at work?     Yes     No  
 Discuss your medical condition with a friend or family member(s)     Yes     No

If yes, whom: \_\_\_\_\_ Please list password for them to verify: \_\_\_\_\_

You must list the name(s) of ALL individuals that we may speak with (ex. caregiver, spouse, etc.) If they are not listed, we will not be able to speak with them.

Please give at least 24 hours of notice, if you cannot keep a scheduled appointment so another person can be served.  
 Failure to give 24 hours notice of cancellation will result in a \$50.00 charge.

Signature \_\_\_\_\_  
 Patient/Responsible Party

Date \_\_\_\_\_

## Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

\_\_\_\_\_  
**PATIENT NAME**

\_\_\_\_\_  
**DATE**

**I understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

**I understand** that Atlanta West Dermatology and Surgery Center, PC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Atlanta West Dermatology and Surgery Center, PC has a detailed document called the '**Notice of Privacy Practices**'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

**I understand** that I have the right to read the '*Notice*' before signing this agreement. If I ask, Atlanta West Dermatology and Surgery Center, PC will provide me with the most current *Notice of Privacy Practices*.

**My signature** below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Atlanta West Dermatology and Surgery Center, PC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Atlanta West Dermatology and Surgery Center, PC has taken action relying on this consent.

\_\_\_\_\_  
**SIGNATURE** (Patient or Legal Custodian/Authorized Representative)

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**Relationship to Patient** if signed by another party

\_\_\_\_\_  
**DATE**

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our '*Notice*' at any time by contacting: Atlanta West Dermatology and Surgery Center, PC.

**FORM Us**



## Atlanta West Dermatology & Surgery Center, P.C.

1550 Mulkey Road  
Austell, Georgia 30106  
770-732-1137

### Financial Policy:

To provide care to as many patients as possible without excessive financial burdens to you, Atlanta West Dermatology & Surgery Center, P.C. makes an effort to accept a large number of health insurance policies. To further assist you, we usually file insurance claims on your behalf. For a variety of reasons, many insurance carriers have placed restrictions on covered benefits and covered medications. When medically essential, we will attempt to overcome these restrictions, but the ultimate decision rests with your insurance carrier.

These are a variety of conditions which are routinely NOT covered by health insurance. These include all treatment for cosmetic problems, including removal of benign lesions, such as skin tags, seborrheic keratoses and normal moles, revisions of scars, and evaluation and treatment of many types of hair loss. If you undergo a treatment for a procedure which is deemed medically unnecessary, you will be responsible for payment.

In some instances, your insurance carrier may determine that a procedure is considered to be a surgical procedure. If this occurs, the surgical procedure could be applied to your deductible and therefore you would be responsible for payment.

Our staff will make every effort to pre-certify medically essential medications. Please understand that even with letters of medical necessity from your doctor, certain plans do not cover specific medications or require failures of other treatment options. If your health insurance carrier denies coverage, you are still able to obtain these medications, but you will have to pay out-of-pocket. In addition, although most vitamin-A derived creams, such as Retin-A, Renova and Avage, are covered during adolescence and acne-prone years, because these creams are also used for anti-aging, they are often NOT covered in adult patients. We do not pre-certify coverage of these creams.

We appreciate the opportunity to care for you and will work with you and your insurance carrier to obtain the best possible treatment for you and your family. If you have any questions regarding billing or covered procedures, our office staff will be happy to assist you.

We have checked your benefits and you have a \$\_\_\_\_\_ copay and \$\_\_\_\_\_ remaining on your deductible. All payments are due on the date of service. If payment is not made on the date of service a \$50 service fee will be added to your account. In addition to the \$50 service fee we will not honor any prescriptions until your account has been satisfied.

I have read and understand the policies as stated above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

After patient has received notice of balance due for 60 days, the following protocol will be followed: In the event that Obligor is 30 days in arrears, then the unpaid balance will accrue interest from the date of service at the rate of 1.5% monthly 18% annually. In the event of default and referral to an attorney or collections agency, the undersigned Obligor shall be liable for all collection fees incurred up to and including the maximum amount allowed under O.C.G.A. 13-1-11 (or such successor to said statute).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date